	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION	(X3) DATE S COMPLE	
					R	2
		FCL032088	B. WING		04/3	0/2021
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STAT			
ELSIE-DO	RIS FAMILY CARE HOME		RRYGROVE STRI I, NC 27703	E T		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
C 000	Initial Comments		C 000			
		sure Section conducted an survey on 04/29/21 and none exit on 04/30/21.				
C 186	10A NCAC 13G .0601 Other Staff	(b)(1) Management And	C 186			
	10A NCAC 13G .0601 Staff	Management And Other				
	or supervisor-in-charge responsible for assuring are carried out in the later than the later than time is a resider without a staff member cited in Paragraph (c) occasional absence of supervisor-in-charge, arrangements shall be (1). The administrator reside within 500 feet of two-way telecommon all times. When the at the licensed home, the staff member who live each shift and the administrator to the licensed home, the staff member who live each shift and the administrator to the licensed home, the staff member who live each shift and the administrator than the licensed home, the staff member who live each shift and the administrator than the licensed home, the staff member who live each shift and the administrator than the license has the license that the license has the license than the licen	ng that all required duties home and for assuring that all left alone in the home er. Except for the provisions of this Rule regarding the f the administrator or one of the following e used: I shall be in the home or of the home with a means unication with the home at dministrator does not live in ere shall be at least one es in the home or one on ministrator shall be directly ng that all required duties				
		and interviews, the facility resident (#1) was not left				

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		FCL032088	B. WING		R 04/3	0/2021
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE	, 00	<u></u>
FI SIF-DO	RIS FAMILY CARE HOMI	306 CHERF	RYGROVE STR	REET		
		DURHAM, I	NC 27703			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
C 186	Continued From page	÷ 1	C 186			
	The findings are:					
	revealed: -At 9:25am the facility -At 9:32am a resident and sat on the front p -At 9:34am the Super observed crossing the and entering the facili Interview with the SIC revealed: -There was no other s but herShe left residents ald errandsShe had been told if the facility, she was a in the facilityShe had gone to the appointment for anoth -She was unable to re-	visor-in-Charge (SIC) was estreet in front of the facility ty. C on 04/29/21 at 9:40am staff working at the facility, one when she had to run she was within 500 feet of ble to leave residents alone				
	04/30/21 at 11:29am -When she opened th told her that she could the house if she was -Sometimes the SIC's boyfriend) stayed in th when the SIC left the -The SICs male friend	e facility in 2008, a surveyor d leave residents alone in within 500 feet away. s male friend (live-in ne house with the residents				

Division of Health Service Regulation

Review of Resident #1's current FL2 dated

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			_		R
		FCL032088	B. WING		04/30/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
ELSIE-DO	RIS FAMILY CARE HOM	E 306 CHERF	RYGROVE STR NC 27703	REET	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
C 186	Continued From page	2	C 186		
	revealed the resident activities of daily living Based on observation	disability. estantly disoriented. 1's care plan dated 03/25/20 was independent with all g. n, record review, and			
		rmined Resident #1 was not			
	and Medical Examina 10A NCAC 13G .0702 Medical Examination (c) The results of the to be entered on the I Medicaid Program Lo MR-2, North Carolina Retardation Services, following: (4) If the information of clear or is insufficient supervisor-in-charge	2 Tuberculosis Test and complete examination are FL-2, North Carolina ng Term Care Services, or Medicaid Program Mental which shall comply with the on the FL-2 or MR-2 is not the administrator or shall contact the physician			
	for clarification in order services of the facility needs. This Rule is not met Based on interviews a facility failed to contact clarification of incomp	er to determine if the can meet the individual's as evidenced by: and record reviews, the			

Division of Health Service Regulation

STATE FORM 6899 If continuation sheet 3 of 51 EKQJ11

	OF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING		_
		FCL032088	B. WING		R 04/30/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
ELSIE-DO	RIS FAMILY CARE HOMI	E 306 CHERF	RYGROVE STR NC 27703	REET	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
C 207	Continued From page	⊋ 3	C 207		
	1. Review of Residen 07/23/20 revealed: -Diagnoses included sintellectual disabledThere were no medications on the later was a handwright of the later was an entry from the later was an entry fro	schizophrenia, borderline cations listed on the FL2. itten note "see list" under FL2. ached to the FL2. et's April 2021 medication (MAR) revealed: for haloperidol 10mg (an treat behaviors) once daily stration at 8:00am. tation haloperidol 10mg was /01/21 through 04/30/21. for omeprazole 20mg (used nce daily scheduled for 0am. tation omeprazole 20mg m 04/01/21 through for combigan 0.2% eye nigh pressure in the eyes due ally scheduled for 0am and 8:00pm. tation combigan eye drops om 04/01/21 through umentation). for quetiapine 50mg (an treat schizophrenia) twice dministration at 8:00am and tation quetiapine 50mg was ally 04/01/21 through for atorvastatin 10mg (an			
	-There was an entry f	for atorvastatin 10mg (an ed to treat high cholesterol neduled for administration at			

Division of Health Service Regulation

STATE FORM 6899 EKQJ11 If continuation sheet 4 of 51

DIVISION	n nealth Service Regu	lation			_
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					R
		FCL032088	B. WING		04/30/2021
NAME OF B	20,425, 02, 01, 125, 155	0.7.7.7.1.		TE 710 0005	
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA		
ELSIE-DO	RIS FAMILY CARE HOMI	E	RRYGROVE STE	REET	
		DURHAM	, NC 27703		
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL	
PREFIX TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROI	
				DEFICIENCY)	
C 207	Continued From page	e 4	C 207		
	8:00pm.				
	•	nentation atorvastatin 10mg			
	was administered.	ionation atorvatiatin romg			
	-	ent #1's medications on			
	hand at the facility on	04/29/21 at 11:56am			
	revealed:				
	 -Haloperidol 10mg wa administration. 	as available for			
	-Omeprazole 20mg w	vas available for			
	administration.	ao avanasio ioi			
		drops were not available for			
	administration.	•			
	-Atorvastatin 10mg w	as not available for			
	administration.				
	-Quetiapine 50mg wa	s available for			
	administration.				
	Telephone interview v	vith Resident #1's mental			
	-	/30/21 at 4:21pm revealed:			
	-Currently, Resident #				
	psychotropic medicat	ions, and that was Haldol			
		y four weeks, and viutrol 280			
	via injection every fou				
	ŭ	s discontinued a long time			
	ago. The facility should be	ave contacted him if they			
	had questions about t				
	quodiono about t				
	Attempted telephone	interview with Resident #1's			
		er (PCP) on 04/30/21 at			
	1:56pm was unsucce	ssful.			
	Danadan	ann alaamiatiana aast			
	Based on record review	ew, observations and rmined that Resident #1 was			
	not interviewable.	minieu that Nesidellt #1 Was			
	not intolviewable.				
	Refer to interview with	h the Supervisor-In-Charge			
	on 04/29/21 at 12:30p				

Division of Health Service Regulation

STATE FORM 6899 EKQJ11 If continuation sheet 5 of 51

Division of	<u>of Health Service Regu</u>	lation				
STATEMENT OF DEFICIENCIES (X1) PROV		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBE		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	ETED
			7 20.12510.			
					R	
		FCL032088	B. WING		04/3	0/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE ZIP CODE		
TO WILL OF TH	NOVIDER OR GOLF EIER		, ,	,		
ELSIE-DO	RIS FAMILY CARE HOM	E	RRYGROVE STR	KEEI		
		DURHAN	I, NC 27703			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE DATE
TAG	REGULATORT OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	MAIE	
				,		
C 207	Continued From page	e 5	C 207			I
	Defer to talanhana ini	tondow with the				I
	Refer to telephone in					I
	Administrator on 04/2	9/21 at 11:29am.				1
	2 Paviou of Posidon	t #2's current FL2 dated				1
	12/26/20 revealed:	t #2 5 Current i L2 dated				1
	-Diagnoses included	hypertension mild				1
		schizoaffective disorder,				ı
	hyperlipidemia.	someonive disorder,				ı
	-Resident #2 was cor	stantly disoriented				1
		cations listed on the FL2.				1
		itten note "see attached list"				1
	under "Medications"					1
	-There was no list atta					1
	medications.	ached to the LZ with				1
	medications.					I
	Review of Resident #	2's April 2021 medication				1
	administration record					I
		for amlodipine 10mg (used				1
		essure) once daily was				1
	scheduled for adminis	,				1
		tation amlodipine 10mg was				1
		ally from 04/01/21 through				1
		imentation with 31 days).				1
	,	or aripiprazole 30mg (used				1
	_	disorders) once daily				I
	scheduled for adminis	,				1
		tation aripiprazole 30mg				
	was administered one					1
	through 04/31/21.					1
	_	or aspirin 81mg (used to				
		and thins the blood) once				1
		dministration at 8:00am.				
	•	tation aspirin 81mg was				
		ally from 04/01/21 through				
	04/31/21.	,				
		or clonazepam 1mg (an				ı
		ed to treat seizures) once				
		dministration at 8:00am.				
		tation clonazepam 1mg was				
		illy from 04/01/21 through				
		,	1			

STATE FORM 6899 EKQJ11 If continuation sheet 6 of 51

Division of	of Health Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
						,
		FOI 020000	B. WING		F	
		FCL032088			04/3	30/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ATE, ZIP CODE		
		306 CHEF	RRYGROVE ST	REET		
ELSIE-DO	RIS FAMILY CARE HOM	E	, NC 27703			
	CUMMA DV CT			DROVIDEDIC DI ANI CE CODDECTIO		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	,	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR		DATE
				DEFICIENCY)		
C 207	Continued From page	2.6	C 207			
0 20.			0 20.			
	04/31/21.					
	_	or fluticasone 50mcg (used				
		of hay fever and other				
		s into both nostrils once				
		for administration at 8:00am.				
		tation fluticasone 50mcg				
		ce daily from 04/01/21				
	through 04/31/21.					
	_	or hydrochlorothiazide				
	12.5mg once daily wa					
	administration at 8:00					
		tation hydrochlorothiazide				
		uretic used to treat high				
		administered once daily from				
	04/01/21 through 04/3					
		or isosorbide extended				
	_ ,	notic diuretic used to treat				
	glaucoma) once daily administration at 8:00					
		tation isosorbide 60mg was				
		ally from 04/01/21 through				
	04/31/21.	-				
		for lithium carbonate 300mg				
	(an antimanic agent					
	episodes) 2 capsules	()				
	scheduled for adminis					
		tation lithium carbonate				
	600mg was administe 04/01/21 through 04/3	31/21.				
	•	or multi vite tablets (vitamin				
	supplements)once da	-				
	administration at 8:00					
	-There was documen					
		aily from 04/01/21 through				
	04/31/21.					
		for pantoprazole 20mg (used				
	· ·	nce daily scheduled for				
	administration at 8:00					
		tation pantoprazole 20mg ce daily from 04/01/21				

Division of Health Service Regulation

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STATEMEN	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		FCL032088	B. WING		R 04/30/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
ELSIE-DO	RIS FAMILY CARE HOM		RYGROVE STR NC 27703	REET		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE	
C 207	release 8 meq (used levels) 2 tablets (16 n for administration at 8 -There was documen was administered one through 04/31/21There was an entry for treat high cholester scheduled for administered once da 04/31/21There was an entry for treat low vitamin B-12 scheduled for administered low vitamin B-12 scheduled for administered once da 04/31/21There was an entry for treat Parkinson's documen administered for administered for administered low administered dai through 04/31/21There was no documen was administered at 8 through 04/31/21There was an entry for administered once dai through 04/31/21There was an entry for administered once dai through 04/31/21There was no documen administered once dai through 04/31/21There was no documen administered once dai through 04/31/21.	for potassium extended to treat low potassium neq) once daily scheduled 3:00am. Itation potassium 16 meq or daily from 04/01/21 for Pravastatin 40mg (used rol levels) once daily stration at 8:00pm. Itation Pravastatin 40mg was aily from 04/01/21 through for vitamin B-12 (used to 2 levels) once daily stration at 8:00am. Itation vitamin B-12 was aily from 04/01/21 through for benztropine 0.5mg (used isease) twice daily stration at 8:00am and for benztropine 0.5mg (used isease) twice daily stration benztropine 0.5mg (used isease) twice daily stration benztropine 0.5mg (used to sure) twice daily scheduled 8:00am from 04/01/21 for metoprolol 25mg (used to sure) twice daily scheduled 8:00am and 8:00pm. Itation metoprolol 25mg was aily at 8:00am from 04/01/21 for metoprolol 25mg metoprolol 25mg was aily at 8:00am from 04/01/21 for metoprolol 25mg metoprolol 25mg was aily at 8:00am from 04/01/21 for metoprolol 25mg metoprolol 25mg was aily at 8:00am from 04/01/21 for metoprolol 25mg metoprolol 25mg was aily at 8:00am from 04/01/21	C 207			

Division of Health Service Regulation

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DIVISION	n nealth Service Negu	ialion			
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
					R
		FCL032088	B. WING		04/30/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ATE, ZIP CODE	
EL SIE DO	RIS FAMILY CARE HOMI	g 306 CHER	RYGROVE ST	REET	
ELSIE-DO	KIS FAMILI CARE HOM	DURHAM,	NC 27703		
(V4) ID	SLIMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (VE)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD	(-/
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP	
				DEFICIENCY)	
			1		
C 207	Continued From page	e 8	C 207		
	treat and manage her	art disease and lower blood			
	pressure) three times				
		am 2:00pm and 8:00pm.			
		n fish oil was administered			
	at 8:00am from 04/01	/21 through 04/31/21.			
	-There was no docum	nentation fish oil was			
	administered at 2:00p	om and 8:00pm from			
	04/01/21 through 04/3	31/21.			
	_	or melatonin 1mg (used to			
	treat insomnia) at bed	- ,			
	administration at 8:00				
		tation melatonin 1mg was			
	1	/01/21 through 04/31/21.			
		or quetiapine 25mg (an			
		treat schizophrenia) once			
	daily at bedtime sche	duled for administration at			
	8:00pm.				
	-There was document	tation quetiapine 25mg was			
		nily at bedtime from 04/01/21			
	through 04/31.	•			
	Observation of Reside	ent #2's medications on			
	hand at the facility on				
	-	04/29/21 at 11.30am			
	revealed:				
	-Amlodipine 10mg wa	is available for			
	administration.				
	-Aripiprazole 30mg w	as available for			
	administration.				
		ailable for administration.			
	-Clonazepam 1mg wa	as available for			
	administration.				
	-Fluticasone 50mcg w	vas not available for			
	administration.				
		12.5mg was available for			
	administration.	cg was available for			
		release 60mg was not			
		•			
	available for administ				
		00mg was available for			
	administration.				

Division of Health Service Regulation

-Multi vite tablets was not available for

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Division of	of Health Service Regu	liation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLI	ETED
			_		1 _	
			D WING		R	
		FCL032088	B. WING		04/3	30/2021
NAME OF D	ROVIDER OR SUPPLIER	QTDEET ADI	DRESS, CITY, STA	ATE ZID CODE		
NAME OF PI	TOVIDER OR SUPPLIER		, ,	,		
FI SIF-DO	RIS FAMILY CARE HOMI	F 306 CHER	RYGROVE STR	REET		
		DURHAM,	NC 27703			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	٧	(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR L	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE	RIATE	DATE
				DEFICIENCY)		
C 207	Continued From page	o 0	C 207			
0 20,	Continued From page	3 9	0 201			
	administration.		1			
	-Pantoprazole 20mg v	was available for				
	administration.	, a.				
		l release 8 meq 2 tablets (16				
		•				
	meq) was available for					
	-Pravastatin 40mg wa	as available for				
	administration.					
	-Vitamin B-12 once da	aily was available for				
	administration.					
	-Benztropine was ava	ailable for administration.				
	-Metoprolol was avail	lable for administration.				
	-Fish oil was available					
		vailable for administration.				
		lable for administration.				
	-Quoliapino mas a.s	lable for administration.				
	Tolonhone interview v	with the facility's contracted				
		21 at 11:45am revealed:				
	-					
		ations were cycle filled each				
	month.					
		current orders for most of				
	Resident #2's medica					
		ot have current orders for				
	over-the-counter med	dications such as B-12, last				
	filled on 08/02/18; fish	h oil, last filled on 08/16/19;				
		on 08/18/18; multi-vitamin,				
	last filled on 10/17/17	•				
	12/19/18; fluticasone					
		oide extended-release, last				
	filled on 08/16/19.	Jue exteriueu-reicase, iast				
		·				
	•	urchase these medications				
		y but over-the-counter			ļ	
	(OTC) to save money				ļ	
		ns not dispensed by the			ļ	
	pharmacy were printe	ed on the MAR for			ļ	
	documentation purpor	ses.				
	-Other medications no	ot dispensed by the			ļ	
		uticasone, isosorbide and			ļ	
	melatonin.	,			ļ	
	meiatoriiri.		1			

Division of Health Service Regulation

Attempted interview with Resident #2 on 04/30/21

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					R
		FCL032088	B. WING		04/30/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STAT	E, ZIP CODE	
EL SIE DO	RIS FAMILY CARE HOME	306 CHE	RRYGROVE STR	EET	
ELSIE-DO	RIS FAMILY CARE HOME	DURHAN	I, NC 27703		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
C 207	Continued From page	10	C 207		
	at 9:38am was unsuc	cessful.			
		interview with Resident #2's r (PCP) on 04/30/21 at ssful.			
	Refer to interview with on 04/29/21 at 12:30p	n the Supervisor-In-Charge om.			
	Refer to telephone int Administrator on 04/2				
	10/22/20 revealed: -Diagnoses included s depression, and dysp -There were no medic -There was a handwri under the "medication"	cations listed on the FL2. Itten note "see attachment" Is of the FL2. Inents attached to the FL2.			
	administration record -There was an entry for the treat and prevent of scheduled for administration and administered one of through 04/29/21There was an entry for treat Parkinson's dise for administration at 80-There was no docum was administeredThere was an entry for (used to treat liver dispersion and the scheduler)	or alendronate 70mg (used steoporosis) once a week stration weekly. Lation alendronate 70mg the daily from 04/01/21 or benztropine 1mg (used to lase) once daily scheduled 1:00am. Lientation benztropine 1mg or enulose solution 20gm ease) once daily scheduled			

Division of Health Service Regulation

STATE FORM 6899 EKQJ11 If continuation sheet 11 of 51

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SU	
			A. BUILDING: _	A. BUILDING:		
		FOI 020000	B WING		R	
		FCL032088	B. Wii(0		04/30	0/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
FI SIF-DO	RIS FAMILY CARE HOM	306 CHEF	RRYGROVE STR	REET		
		DURHAM	, NC 27703			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
C 207	Continued From page	e 11	C 207			
	20mg was administer through 04/30/21. -There was an entry f to treat mental/mood scheduled for administration at 8:00. -There was an entry f to treat acid reflux) or administration at 8:00. -There was documen was administration at 8:00. -There was documen was administration at 8:00. -There was documen was administration at 8:00. -There was documen 3350 powder 17gm w from 04/01/21 through -There was an entry f release 75mg (used to capsules (150mg) on administration at 8:00. -There was an entry f release 75mg (used to capsules (150mg) on administration at 8:00. -There was documen was administered one through 04/30/21. -There was an entry f (used to treat mild pathree times daily schell 8:00am, 2:00pm and -There was documen 650mg was administer 04/01/21 through 04/0. -There was documen 650mg was administer 04/07/21 through 04/0.	or olanzapine 15mg (used disorders) once daily was stration at 8:00am. tation olanzapine 15mg was sily from 04/01/21 through or omeprazole 20mg (used nee daily was scheduled for fam. tation omeprazole 20mg ce daily from 04/01/21 as 350 powder 17gm (used to be daily was scheduled for fam. tation polyethylene glycol was administered once daily in 04/30/21. For venlafaxine extended to treat depression) take 3 ce daily scheduled for fam. tation venlafaxine 150mg are daily from 04/01/21 for acetaminophen 325mg in/fever) 2 tablets (650mg) and deduced for administration at 8:00pm. tation acetaminophen ared three times daily from 06/21. tation acetaminophen ared once daily from 30/21.				
	04/01/21 through 04/0 -There was documen 650mg was administe 04/07/21 through 04/3 -There was an entry f	06/21. tation acetaminophen ered once daily from				

Division of Health Service Regulation

blood clots) subcutaneously every 12 hours

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
			B WING		R
		FCL032088	B. WING		04/30/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
EI SIE DO	RIS FAMILY CARE HOMI	306 CHEF	RRYGROVE STR	REET	
EL3IE-DO	RIS FAMILI CARE HOMI	DURHAM	, NC 27703		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
C 207	07 Continued From page 12		C 207		
	scheduled for adminis 8:00pm. -There was document administered once da 04/30/21. -There was an entry from the treat seizures and its scheduled for adminis 8:00pm. -There was document was administered once through 04/30/21. -There was an entry from through 04/30/21. -There was an entry from the treat symptoms of a scheduled for administered. -There was an entry from the treat symptoms of a scheduled for administered once da 04/30/21. Observation of Reside hand at the facility on revealed: -Alendronate 70mg wadministration -Benztropine 1mg wardministration -Enulose solution 20gradministration	stration at 8:00am and station enoxaparin 80mg was ily from 04/01/21 through or gabapentin 300mg (used nerve pain) twice daily stration at 8:00am and station gabapentin 300mg se daily from 04/01/21 or senexon-S (used to treat ily scheduled for am and 8:00pm. sentation senexon-S was or tamsulosin 0.4mg (used enlarge prostate) at bedtime stration at 8:00pm. station tamsulosin 0.4mg was ily from 04/01/21 and ent #3's medications on 04/29/21 at 11:59am as not available for im was not available for			
	-Olanzapine 15mg wa administration -Omeprazole 20mg w administration				
		3350 powder 17gm was not			

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available for administration

-Venlafaxine extended release 75mg was not

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Division of	Division of Health Service Regulation					
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	ETED
					-	,
		FCL032088	B. WING		04/2	80/2021
		FGE032000			04/3	0/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
=: 0:= = 0	DIO 544411 V 04 DE 11041	_ 306 CHER	RYGROVE ST	REET		
ELSIE-DO	RIS FAMILY CARE HOM	E DURHAM,	NC 27703			
(VA) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N.	(VE)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE	RIATE	DATE
				DEFICIENCY)		
C 207	Continued From page 13		C 207			
0 20.	Official and the state of the s		0 20.			
	available for administration					
	-Acetaminophen 325r	mg was available for				
	administration					
	-Acetaminophen 650r	mg was available for				
	administration					
	-Enoxaparin 80mg wa	as not available for				
	administration					
	-Gabapentin 300mg v	was available for				
	administration					
	-Senexon-S was not a	available for administration				
	-Tamsulosin 0.4mg					
		with Resident #3's Primary				
	, ,	on 04/30/21 at 9:18am				
	revealed:					
	** *	t medications included:				
	-Benztropine 1mg one					
	-Gabapentin 300mg t					
	-Olanzapine 15mg on					
	-Omeprazole 20mg o					
	-Invega injection once					
	•	ce daily with a glass of fluid.				
	-If Resident #3 was a					
	medications they wer	e not ordered by the PCP.				
	Talambana intendessa					
		with the facility's contracted				
	•	1 at 11:16am revealed:				
	-	Resident #3's medications				
	every month.	and for hon-traning 1mg				
		red for benztropine 1mg				
	once daily dated 09/1	last filled and dispensed on				
		•				
	04/26/21 for a quantit				ĺ	
		for omeprazole 20mg once			ĺ	
	daily dated 09/08/20.	last filled and dispensed an				
		last filled and dispensed on			ĺ	
	03/30/21 for a quantit					
	- mere was an order	for gabapentin twice daily			ŀ	

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dated 04/02/21.

-The medication was filled and dispensed on

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DIVISION	n nealth Service Regu	lialion	_			
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A BUILDING:		COMPL	.ETED
					F	₹
		FCL032088	B. WING		04/3	30/2021
					,	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	ATE, ZIP CODE		
EI SIE DO	RIS FAMILY CARE HOM	age 306 CHER	RYGROVE ST	REET		
LLSIL-DO	NISTAMILI CARL HOM	DURHAM,	NC 27703			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION)N	(X5)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR L	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROF	RIATE	DATE
				DEFICIENCY)		
0.007	- · · · -		0.007			
C 207	Continued From page	e 14	C 207			
	04/02/21 for a quantit	ty of 60 tablets.				
		for olanzapine 15mg once				
	daily dated 04/28/21.					
	-					
		as filled and dispensed on				
	04/28/21 for a quantit					
		s for alendronate 70mg				
		e solution 20gm once daily,				
		350 powder 17gm once				
	daily, venlafaxine exte	ended release 75mg take 3				
	capsules (150mg) on	ce daily, acetaminophen				
	325mg 2 tablets (650	mg) three times daily,				
	•	ocutaneously every 12 hours,				
		y and tamsulosin 0.4mg at				
	bedtime.	y and tambulosin oing at				
	beduine.					
	A44 4 1 ! 4 !					
	-	with Resident #3 on 04/29/21				
	at 9:40am was unsuc	ccessful.				
		h the Supervisor-In-Charge				
	on 04/29/21 at 12:30p	pm.				
	Refer to telephone int	terview with the				
	Administrator on 04/2	29/21 at 11:29am.				
	Interview with the Sur	 pervisor-In-Charge (SIC) on				
	04/29/21 at 12:30pm.	,				
	-She did not know the					
	ordered for the reside					
		=.				
	-When FL2s were sig					
	sometimes wrote "see					
		id not attach a medication				
	list.					
		the PCP to obtain a list of the				
	current medications.					
	-She administered me	edications based on the				
	medications received	from the pharmacy				
		cy had the current orders.				
		- , a ca c c. a				
	Telephone interview	with the Administrator on				
	relebitorie litterview v	with the Authinianator on	1			1

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04/30/21 at 11:29am revealed:

STATE FORM 6899 EKQJ11 If continuation sheet 15 of 51

Division of	<u>of Health Service Regu</u>	ılation			
	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					_B
		FCL032088	B. WING		R 04/30/2021
		FCL032088			04/30/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE	
		_ 306 CHE	RRYGROVE STR	REET	
ELSIE-DO	RIS FAMILY CARE HOM	E DURHAM	I, NC 27703		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)
PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE DATE
				22,	
C 207	Continued From page 15		C 207		
		ny residents had FL2s that ed medication list when there			
	was no list.	a medication list when there			
		ted "see attached list" the			
	PCP always provided				
	medications.	an attached het er			
		from the PCP there was a			
	list of medications atta				
		ad taken the paperwork out			
	of the residents' recor				
	-She expected the SI	C to go through the			
		d make sure everything was			
	in the record.				
	-The SIC should be g	joing through the records at			
	least once per month.				
		the facility like she was			
	supposed to be.				
C 249	10A NCAC 13G .0902	2(c)(3)(4) Health Care	C 249		
	10A NCAC 13G .0902				
		assure documentation of the			
	following in the reside				
	l ` ´	es, treatments or orders from			
	'.'	icensed health professional;			
	and (4) implementation of	f procedures, treatments or			
	. , .	ubparagraph (c)(3) of this			
	Rule.	apparagraph (C)(O) or uno			
	raic.				
	This Rule is not met	as evidenced by:			
		ews and interviews, the			
		e blood pressure (BP)			
	checks were impleme	ented and documented as			
		npled residents (Resident			
	#2) with orders for weekly BP checks.				

The findings are:

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		. ,	(X3) DATE SURVEY COMPLETED	
			7.1. 20.125101			R
		FCL032088	B. WING		04	1/30/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE		
EL CIE DO	DIC FAMILY CADE LIOM	_ 306 CHE	RRYGROVE STRE	ET		
ELSIE-DO	RIS FAMILY CARE HOM	DURHAN	I, NC 27703			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
C 249	C 249 Continued From page 16		C 249			
	12/26/20 revealed dia hypertension, mild into schizoaffective disordance. There was an order administration recordance. There was an entry to weekly. There were no document was a from 03/01/21 to Review of Resident # revealed:	dellectual disability, der and hyperlipidemia. for weekly BP monitoring. E2's March 2021 medication (MAR) revealed: co check BP and record mented BP readings on the hrough 03/31/21.				
	weekly.	mented BP readings on the				
	04/29/21 at 12:50pm -When an FL2 was re Provider (PCP) she re in the resident's record -She did not review the -She did not know Re weekly BP checks.	eturned by the Primary Care eceived the FL2 and filed it rd.				
	04/30/21 at 11:29am -She expected the SI FL2 and check the re the PCPShe did not know Re weekly BPShe had not reviewe	with the Administrator on revealed: C to follow the orders on the sident's BP as ordered by esident #2 had and order for d Resident #2's current FL2. sible for checking the				

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STATE FORM EKQJ11 If continuation sheet 17 of 51

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		FCL032088	B. WING		R
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE ZIP CODE	04/30/2021
	RIS FAMILY CARE HOM	306 CHER	RYGROVE STR		
ELSIE-DC	TAMILI CARE HOM	DURHAM,	NC 27703		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
C 249	Continued From page 17		C 249		
	residents' records dai were implemented.	ly and ensuring PCP orders			
	Attempted interview v at 9:38am was unsuc	vith Resident #2 on 04/29/21 cessful.			
	Attempted telephone interview with Resident #2's Primary Care Provider (PCP) on 04/30/21 at 4:37pm was unsuccessful.				
C 315	10A NCAC 13G .1002	2(a) Medication Orders	C 315		
	10A NCAC 13G .1002 Medication Orders (a) A family care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record.				
This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to contact the Primary Care Provider (PCP) for 1 of 3 sampled residents (Resident #1) for clarification of orders related to a antipsychotic medications, a proton pump inhibitor, cholesterol medication, and an eye drop. The findings are:					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		FCL032088	B. WING	B. WING		0/2021
ELSIE-DORIS FAMILY CARE HOME 306 CHER			DRESS, CITY, STA RYGROVE STF NC 27703		1 04/0	0/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
C 315	Continued From page	2 18	C 315			
	-There was a handwr "Medications" on the -There was no list atta a. Review of Residen 07/23/20 revealed me aripiprazole 7.5mg or schizophrenia). Review of Resident # administration record no entry for aripiprazo Review of Resident # there was no entry for daily. Observation of Reside hand on 04/29/21 at a aripiprazole 7.5mg wa administration. Based on observation interview, it was deter interviewable.	schizophrenia and disability. Cations listed on the FL2. Sitten note "see list" under FL2. Sached to the FL2				

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representative from the facility's contracted

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X		· /	(X3) DATE SURVEY COMPLETED	
			7 t. Boilebiito		R	
		FCL032088	B. WING		I	/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STAT	E, ZIP CODE		
		_ 306 CHEI	RRYGROVE STR	EET		
ELSIE-DO	RIS FAMILY CARE HOM	E DURHAM	I, NC 27703			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
C 315	C 315 Continued From page 19		C 315			
	pharmacy on 04/30/2	1 at 11:16am.				
	b. Review of Resident #1's previous FL2 dated 07/23/20 revealed there was a medication order for omeprazole 20mg once daily (used to treat acid reflux).					
	administration record -There was an entry f daily scheduled for ad	1's March 2021 medication (MAR) revealed: for omeprazole 20mg once diministration at 8:00am. nentation omeprazole 20mg				
	Review of Resident #1's April 2021 MAR revealed: -There was an entry for omeprazole 20mg once dailyThere was documentation omeprazole 20mg was administered once daily from 04/01/21 through 04/28/21.					
	hand on 04/29/21 at a omeprazole 20mg was administrationThere were two bubles omeprazole 20mgOne bubble packed 02/25/20 for a quantite omeprazole capsules -The second bubble-pairs dispensed on 10/14/1 with 19 omeprazole comparisons of the second bubble-pairs	container was dispensed on y of 30 capsules with 22 remaining. packed container was 9 for a quantity of 30 tablets				
		r (PCP) on 04/30/21 at				
	Based on observatior	n, record review and				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	FCL032088	B. WING		R 04/30/2021	
NAME OF PROVIDER OR SUPPLIER ELSIE-DORIS FAMILY CARE HOME		RESS, CITY, STA RYGROVE STR NC 27703			
(X4) ID SUMMARY STATEMEN PREFIX (EACH DEFICIENCY MUST TAG REGULATORY OR LSC IDE	FBE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
interview, it was determined interviewable. Refer to interview with the S (SIC) on 04/29/21 at 12:30g. Refer to the telephone interviewable administrator on 04/30/21 at 12:30g. Refer to the telephone interviewable and the facility of t	Supervisor-In-Charge pm. rview with the at 11:29am. rview with a sility's contracted 1:16am. previous FL2 dated as a medication order daily (used to treat daily (used to treat daily from 03/01/21 detapline 50mg twice stration at 8:00am and displayed from 03/01/21 detapline 50mg twice duetapline 50mg was pm 04/01/21 through detapline form of the medications on the medications on the medication of the medications on the medication.	C 315			

Division of Health Service Regulation

quantity of 60 tablets was dispensed.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _		
		FCL032088	B. WING		R 04/30/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
ELSIE-DO	RIS FAMILY CARE HOM	E 306 CHERI DURHAM,	RYGROVE STR NC 27703	REET	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
C 315	15 Continued From page 21		C 315		
	-The bubble-packed of there were 60 tablets	container was unopened and remaining.			
		interview with Resident #1's er (PCP) on 04/30/21 at ssful.			
	Based on observatior interview, it was deter not interviewable.	n, record review and rmined that Resident #1 was			
	Refer to interview with the Supervisor-In-Charge on 04/29/21 at 12:30pm.				
	Refer to the telephone Administrator on 04/3				
	Refer to the telephone representative from the pharmacy on 04/30/2	ne facility's contracted			
	07/23/20 revealed the	t #1's previous FL2 dated ere was a medication order at bedtime (used to treat			
	administration record -There was an entry f bedtime scheduled fo	or atorvastatin 10mg at r administration at 8:00pm. nentation atorvastatin 10mg			
	Review of Resident #1's April 2021 MAR revealed there was no entry for atorvastatin 10mg on the MAR.				
	Observation of Resident	ent #1's medications on 11:56am revealed			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO			(X3) DATE SURVEY COMPLETED	
		FCL032088	B. WING		04	R J/ 30/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
FI SIF-DO	RIS FAMILY CARE HOM	306 CHE	RRYGROVE STRE	ET		
LLUIL-DO	THE TAINET GARE HOW	DURHAI	M, NC 27703			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
C 315	Continued From page	e 22	C 315			
	atorvastatin 10mg wa administration.	as not available for				
		interview with Resident #1's er (PCP) on 04/30/21 at essful.				
	Based on observation interview, it was dete interviewable.	n, record review, and rmined Resident #1 was not				
	Refer to interview with the Supervisor-In-Charge (SIC) on 04/29/21 at 12:30pm.					
	Refer to the telephon Administrator on 04/3					
	Refer to the telephon representative from the pharmacy on 04/30/2	he facility's contracted				
	07/23/20 revealed the	nt #1's previous FL2 dated ere was a medication order ye drops in both eyes daily hypertension).				
	administration record -There was an entry drops in both eyes tw administration at 8:00	for combigan 0.2% eye vice daily scheduled for Dam and 8:00pm. nentation combigan 0.2%				
		for combigan 0.2% eye vice daily scheduled for				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		FCL032088	B. WING		04	R J/ 30/2021
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STAT	E ZIP CODE	1 0-	70072021
NAME OF T	NOVIDEN ON 3011 EIEN		RRYGROVE STRE			
ELSIE-DO	ORIS FAMILY CARE HOM	E	I, NC 27703			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
C 315	C 315 Continued From page 23		C 315			
		tation combigan 0.2% was aily from 04/01/21 through				
	Observation of Resident #1's medications on hand on 04/29/21 at 11:56am revealed combigan 02% was not available for administration. Attempted telephone interview with Resident #1's Primary Care Provider (PCP) on 04/30/21 at 1:56pm was unsuccessful. Based on observation, record review and interview, it was determined Resident #1 was not interviewable.					
	Refer to interview wit (SIC) on 04/29/21 at	h the Supervisor-In-Charge 12:30pm.				
	Refer to the telephon Administrator on 04/2					
	Refer to the telephon representative from the pharmacy on 04/30/2	ne facility's contracted				
	revealed: -She administered Re	C on 04/29/21 at 12:30pm esident #1's medications				
	the facility from the pl -She did not know Re on the MAR that were -The facility used thre	edications that were sent to harmacy. esident #1 had medications e not available in the facility. ee different pharmacy's and ch pharmacy filled Resident				
	Telephone interview v 04/30/21 at 11:29am	vith the Administrator on revealed:				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (DENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING.		R
		FCL032088	B. WING		04/30/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
ELSIE-DO	RIS FAMILY CARE HOME		RRYGROVE STF	REET	
(V4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	, NC 27703	PROVIDER'S PLAN OF CORRECTION	J (VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
C 315	Continued From page	24	C 315		
	records daily to ensur matched current orde -She had not been at -The SIC knew she had was not sure about a Telephone interview of the facility's contracte 11:16am revealed: -The pharmacy had n medications for over of -In May 2020, the phat for Resident #1. -Prior to May 2020, the medications for Resid 2019. -The facility must be ut fill Resident #1's med	the facility much lately. ad to contact the PCP if she medication order. with a representative from d pharmacy on 04/30/21 at ot filled Resident #1's one year. armacy filled one medication e pharmacy had not filled ent #1 since December using another pharmacy to ications. not providing MARs to the			
C 330	10A NCAC 13G .1004 Administration	l(a) Medication	C 330		
	(a) A family care hom preparation and admi prescription and non-by staff are in accorda (1) orders by a license which are maintained	Medication Administration to shall assure that the nistration of medications, prescription and treatments ance with: ed prescribing practitioner in the resident's record; and n and the facility's policies			
	This Rule is not met a TYPE A2 VIOLATION	-			

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STATE FORM 6899 EKQJ11 If continuation sheet 25 of 51

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 306 CHERRYGROVE STREET DURHAM, NC 27703 PREPIX PREPIX PROVIDER OR SUPPLIED PROVIDERS PLAN OF CORRECTION PREPIX TAG	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X: A. BUILDING:		1 ' '	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER ELSIE-DORIS FAMILY CARE HOME CAPID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE PRECEDED BY FULL TAG CAPID PREFIX TAG CASSO Continued From page 25 Deficiency mist be preceded by Full Page 17 Deficiency mist be preceded by a licensed previous, the facility falled to ensure medications were administered as ordered by a licensed prescribing practitioner for 2 of 3 sampled residents (Residents #1 and #3) related to an anticoagulant injection, an antibiotic ointment, a pain medication and a powdered laxative (#1), a proton pump inhibitor, nerve pain and muscle spasms medications (#3). The findings are: 1. Review of Resident #1's current FL2 dated O7/26/20 revealed: -Diagnoses included schizophrenia and borderline intellectual disability, -Resident #1 was constantly disoriented. a. Review of Resident #1's hospital discharge summary report dated 04/23/21 revealed: -Resident #1 had a car accident and sustained a broken hipResident #1 had surgery to repair the broken hipResident #1 had surgery to repair the broken hipThe discharge summary included a medication order for Lovenox (used to thin the blood) with instructions to inject 40mg subcutaneously once daily for 21 days to prevent blood clots resulting from the surgeryThere were instructions to start Lovenox 40mg			FCL032088	B. WING		04	
CASID SUMMARY STATEMENT OF DEFICIENCES DURHAM, NC 27703	NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		
DURHAM, NC 27703 SUMMARY STATEMENT OF DEFICIENCY WIST BE PRECEDED BY FULL PREFIX RESULTORY OR ISC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE C 330 Continued From page 25 C 330	-: 0:0		_ 306 CHEF	RRYGROVE STRE	ET		
PREFIX TAG EACH DEFICIENCY MUST BE PRECEDED BY FULL REQULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE CROSS-REFERENCED TO THE APPROPRIATE	ELSIE-DO	RIS FAMILY CARE HOM	DURHAM	, NC 27703			
Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered by a licensed prescribing practitioner for 2 of 3 sampled residents (Residents #1 and #3) related to an anticoagulant injection, an antibiotic ointment, a pain medication and a powdered laxative (#1), a proton pump inhibitor, nerve pain and muscle spasms medications (#3). The findings are: 1. Review of Resident #1's current FL2 dated 07/26/20 revealed: -Diagnoses included schizophrenia and borderline intellectual disabilityResident #1 was constantly disoriented. a. Review of Resident #1's hospital discharge summary report dated 04/23/21 revealed: -Resident #1 was hospitalized from 04/14/21 through 04/23/21Resident #1 had a car accident and sustained a broken hipResident #1 had surgery to repair the broken hipResident #1 had surgery to repair the broken hipThe discharge summary included a medication order for Lovenox (used to thin the blood) with instructions to inject 40mg subcutaneously once daily for 21 days to prevent blood clots resulting from the surgeryThere were instructions to start Lovenox 40mg	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T	ION SHOULD BE HE APPROPRIATE	COMPLETE
Review of Resident #1's April 2021 medication administration record (MAR) revealed there was no entry for Lovenox on the MAR. Observation of Resident #1's medications on hand at the facility 04/29/21 at 11:56am revealed: -Lovenox 40mg was available for administration.	C 330	Based on observation reviews, the facility fawere administered as prescribing practitione residents (Residents anticoagulant injection pain medication and a proton pump inhibitor spasms medications. The findings are: 1. Review of Residen 07/26/20 revealed: -Diagnoses included borderline intellectual -Resident #1 was cora. Review of Residen summary report dated -Resident #1 was host through 04/23/21Resident #1 had a cabroken hipResident #1 had surging -The discharge summorder for Lovenox (us instructions to inject 4 daily for 21 days to prefrom the surgeryThere were instruction 04/24/21 and stop Review of Resident #1 administration record no entry for Lovenox. Observation of Resident #1 days of the facility 04 days of the facili	ins, interviews, and record iled to ensure medications ordered by a licensed er for 2 of 3 sampled #1 and #3) related to an in, an antibiotic ointment, a a powdered laxative (#1), a in, nerve pain and muscle (#3). It #1's current FL2 dated schizophrenia and disability. Instantly disoriented. It #1's hospital discharge is oid	C 330			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPL	ETED
					F	₹
		FCL032088	B. WING		04/3	0/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DDRESS, CITY, STA	TE, ZIP CODE		
FI SIF-DO	RIS FAMILY CARE HOM	F 306 CHEF	RRYGROVE STE	REET		
		DURHAM	I, NC 27703			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
C 330	Continued From page	e 26	C 330			
	-There were four vials	s of Lovenox unopened.				
	-Lovenox was dispen					
	Tolonhono intonvious	with a representative from				
		with a representative from ed pharmacy on 04/30/21 at				
	11:16am revealed:					
		pharmacy the order for				
	Resident #1's Loveno	ox on 04/23/21. not filled Resident #1's				
		ne year, so he did not know				
what to do with the orders.						
		one" from the facility called				
		sident #1's medications, then the wrong pharmacy."				
		the order for Lovenox and				
		lelivered to the facility on				
	04/28/21.					
	Telephone interview von 04/30/21 at 9:08ar	with Resident #1's guardian m revealed:				
	-Earlier in the month and his hip was broke	Resident #1 was hit by a car en.				
		the resident was ordered				
		t getting the medication.				
	administered as orde	ent #1's medications to be red.				
	daminiotoroa de orde	104.				
		pervisor-In-Charge (SIC) on				
	04/29/21 at 12:30pm	revealed: vas discharged from the				
	hospital his medication					
	pharmacy.	who work down to the				
	-When medications w	vere sent to the pharmacy,				
		filled, dispensed, and				
	delivered the medical					
	•	ministrator called the ed about Resident #1's				
	medications.					
		elivered to the facility in the				

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evening on 04/28/21.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
					R
		FCL032088	B. WING		04/30/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
		306 CHER	RYGROVE STR	REET	
ELSIE-DO	RIS FAMILY CARE HOM	E DURHAM,			
040.15	CLIMMA DV CT	·			1 000
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
C 330	Continued From page	e 27	C 330		
	she did not know how medicationShe did not know Lo and it was needed to developing a blood cl -She had no reason of contacted the pharma #1's medications beform Telephone interview w 04/30/21 at 11:29am -She had been at the member and did not kneedications were not -She went to the facilithe SIC had not called about Resident #1's reshe immediately call the medication orders -The SIC should have	venox was a blood thinner prevent Resident #1 from ot. or excuse why she did not acy to inquire about Resident ore 04/28/21. with the Administrator on revealed: hospital with her family know Resident #1's administered as ordered. ity on 04/28/21 and noticed d the pharmacy to inquire medications. led the pharmacy to request			
	Attempted telephone interview with Resident #1's Primary Care Provider (PCP) on 04/30/21 at 1:56 pm was unsuccessful.				
	Based on observatior interview, it was deter interviewable.	n, record review and rmined Resident #1 was not			
	summary report dated was an order for baci				

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Review of Resident #1's April MAR revealed there

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
FCL032088		B. WING		R 04/30/2021		
ELSIE-DORIS FAMILY CARE HOME 306 CHEF			PRESS, CITY, STA RYGROVE STR NC 27703	•	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLET	ΓE
W O hare reconstruction of the construction of	and at the facility on evealed: Bacitracin ointment widministration. Review of the pharmacitracin ointment was The bacitracin ointment was The bacitracin ointment was The bacitracin ointment of the bacitracin ointment was the facility's contracted 1:16am revealed: An order for bacitracided/23/21. The pharmacy did not ecause Resident #1's Illed from their pharmation of the facility did not resulted until 04/28/21. Bacitracin ointment was 4/29/21 at 12:30pm of the Resident #1's order fent to the pharmacy She did not call to see to been filled and de On 04/28/21, the Adribarmacy and inquired acitracin ointment. The facility did not resulted until 04/28/21. The pharmacy did not resulted until 04/28/21, the She did not call to see to been filled and de On 04/28/21, the Adribarmacy and inquired acitracin ointment. The facility did not resulted until 04/28/21, the Adribarmacy and inquired acitracin ointment.	ent #1's medications on 04/29/21 at 11:56am vas available for acy printed label revealed as dispensed on 04/28/21. ent container was unopened at had not been used. vith a representative from d pharmacy on 04/30/21 at an ointment was received on the dispense the medication is medications had not been used for over one year. quest the ointment to be a vas filled and dispensed on the dispense on 04/23/21. e why the medication had livered. ministrator called the dispense on the dispense on 04/23/21. e why the medication had livered. ministrator called the dispense on 04/23/21.	C 330			

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#1's medications from the pharmacy.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BUILDING.		R	
		FCL032088	B. WING		1	0/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
ELSIE-DO	RIS FAMILY CARE HOMI	E 306 CHER DURHAM,	RYGROVE STF NC 27703	REET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
C 330	Resident #1's medica 04/23/21 hospital disc -The SIC was suppose after not getting Resident day. Attempted telephone Primary Care Provide pm was unsuccessful Based on observation interview, it was determined interviewable. c. Review of Resident summary report dated was an order for polye (used to treat constipation with instructions to store Review of Resident # was no entry for polye Observation of Resident # was no entry for polye Observation of Resident at the facility on revealed: -Polyethylene glycol padministration and was -The plastic container that had not been administration and was -The plastic contracted the facility's contracted 11:16am revealed: -An order for polyethy received on 04/23/21.	ed the pharmacy to request tion ordered from the charge be filled. ded to contact the pharmacy dent #1's medications the interview with Resident #1's or (PCP) on 04/30/21 at 1:56. In, record review, and remined Resident #1 was not the thickness of the contact the pharmacy dent #1's hospital discharge do 04/23/21 revealed there ethylene glycol powder ation) once daily for 5 days op on 04/28/21. It's April MAR revealed there ethylene glycol powder. The pharmacy on 04/28/21 at 11:56am The powder was available for as dispensed on 04/28/21. The had a securely locked seal ken indicating polyethylene detered. With a representative from the pharmacy on 04/30/21 at the place of the place o	C 330	DEFICIENCY)		
		ot dispense polyethylene 1/28/21 because it had been				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	ETED
		FCL032088	B. WING		04/3	0/2021
NAME OF PI	NAME OF PROVIDER OR SUPPLIER STREET			TE, ZIP CODE		
EI 01E D0	DIO EAMILY OADE HOM	_ 306 CHEF	RRYGROVE STR	REET		
ELSIE-DO	RIS FAMILY CARE HOM	DURHAM	, NC 27703			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
C 330	Continued From page	30	C 330			
	from their pharmacyThe pharmacy was r sent in errorOn 04/28/21, "someo	t #1's medications were filled not sure if the orders were one" from the facility called hylene glycol powder to be				
	04/29/21 at 12:30pm -When medication ord pharmacy to be filled, and dispensed the medication ord -The pharmacy deliver the facilityResident #1's order of the powder was sent to the resident #1's order of the powder was not deliver yesterday, 04/28/21She knew Resident of the powder had not been she did not call to inqueste and no reason of the powder had no reason of the powder had no reason of the powder had no reason of the polyethylene glycol powder had not aware the polyethylene glycol powder had not a	ders were given to the the pharmacy usually filled edication the same day. ered medications directly to for polyethylene glycol ne pharmacy on 04/23/21. for polyethylene glycol ered to the facility until #1's polyethylene glycol delivered to the facility and uire why. why she did not contact the dispensing Resident #1's bowder. he order for Resident #1's bowder was only to be ys after the discharge. with the Administrator on revealed: ity on 04/28/21 and noticed				
	#1's medications from -She immediately call Resident #1's medica 04/23/21 hospital disc -The SIC was suppos	ed the pharmacy to request tion ordered from the				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			7 50.12510.		
		FCL032088	B. WING		R 04/30/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
ELSIE-DO	RIS FAMILY CARE HOM	E 306 CHER DURHAM,	RYGROVE STF NC 27703	REET	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE COMPLETE
C 330	Continued From page	e 31	C 330		
	next day.				
	Attempted telephone interview with Resident #1's Primary Care Provider (PCP) on 04/30/21 at 1:56 pm was unsuccessful.				
	Based on observatior interview, it was deter interviewable.	n, record review and rmined Resident #1 was not			
	summary report dated was an order for acet treat pain) every six h	t #1's hospital discharge d 04/23/21 revealed there aminophen 325mg (used to lours for 15 days with cetaminophen on 05/08/21.			
	Review of Resident # was no entry for acet	1's April MAR revealed there aminophen 325mg.			
	hand at the facility on revealed: -Acetaminophen 325i administration. -Acetaminophen 325i				
	the facility's contracted 11:16am revealed: -An order for acetami received on 04/23/21 -The pharmacy did not 325mg because no orequest the medication -On 04/28/21, "someound requested acetary -On 04/28/21, acetam	ot dispense acetaminophen ne at the facility called to on be filled. One" from the facility called minophen 325mg to be filled.			

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			P WING		R	
		FCL032088	B. WING		04/30/2021	
NAME OF PI	NAME OF PROVIDER OR SUPPLIER STREET A			TE, ZIP CODE		
ELSIE-DO	RIS FAMILY CARE HOM	E	RRYGROVE STE	REET		
		DURHAN	I, NC 27703			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
C 330	Continued From page	e 32	C 330			
	facility.					
	04/29/21 at 12:30pm -Resident #1's order f was sent to the pharm -Resident #1's order f was not delivered to t 04/28/21She knew Resident # had not been delivered not call to inquire why deliveredShe had no reason of contact the pharmacy Resident #1's acetam Telephone interview w 04/30/21 at 11:29am -Resident #1 was hit ended up having surg -On 04/28/21, she we Resident #1's medicat the pharmacyShe immediately call requested Resident # -The SIC should have inquire about Resider first day the medication Attempted telephone Primary Care Provide pm was unsuccessful Based on observation	for acetaminophen 325mg macy on 04/23/21. for acetaminophen 325mg he facility until yesterday, for acetaminophen 325mg he facility until yesterday, for acetaminophen 325mg de to the facility and she did for the medication was not for excuse why she did not for exc				
	Refer to the telephone	e interview with the				

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Administrator on 04/30/21 at 11:29am.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					R	
		FCL032088	B. WING		04/30/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE ZIP CODE	-	
NAME OF T	NOVIDEN ON GOLL FIELD		RYGROVE STF	,		
ELSIE-DO	RIS FAMILY CARE HOM	E	NC 27703	CL I		
	CUMMA DV CT	<u> </u>		DROVIDEDIC DI ANI OF CORDECTION		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
C 330	Continued From page	e 33	C 330			
	revealed: -Diagnoses included acid reflux, neuropath dysphonia, and benig-Resident #3 was cor-There were no medic-There was a handwr attached" documented the FL2There was no medic-FL2. a. Review of Resident 03/25/20 revealed: -There were orders for omeprazole 20mg on reflux). Review of Resident # administration recording entry for omeprazole 20mg on reflux).	an prostatic hyperplasia. Instantly disoriented. Instantly disorient				
	Review of Resident # revealed: -There was an entry f	t3's April 2021 MAR for omeprazole 20mg once				
	daily scheduled for a	dministration at 8:00am.				
	-There was documen					
	omeprazole 20mg wa 04/01/21 through 04/2	as administered daily from 29/21 at 8:00am.				
	Observation of Resid hand at the facility on revealed omeprazole administration.	ent #3's medications on n 04/29/21 at 11:59am n 20mg was not available for				
		with Resident #3's Primary on 04/30/21 at 9:18am				

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revealed:

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		A. BUILDING: _	A. BUILDING:			
	FCL032088	B. WING			R / 30/2021	
NAME OF PROVIDER OR SUPPLIER	STREET AI	ODRESS, CITY, STAT	E, ZIP CODE			
ELSIE-DORIS FAMILY CARE H	OME	RRYGROVE STR I, NC 27703	EET			
PREFIX (EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
omeprazole 20mg -Resident #3 was once daily due to a -He expected ome administered daily Telephone intervie the facility's contra 11:16am revealed -The pharmacy fill every monthThe last order the omeprazole was o -The medication w 03/30/21 for a qua Telephone intervie Supervisor-In-Cha 4:03pm revealed: -She administered dailyIf omeprazole was sent from the phan -She did not alway medications on the medicationsShe was unable to #3 was administered at 9:40am was un Refer to the teleph Administrator on 0 b. Review of Resid 03/25/20 revealed	rent medications included once daily. ordered omeprazole 20mg a diagnosis of acid reflux. exprazole 20mg to be as ordered. ew with a representative from acted pharmacy on 04/30/21 at acted pharmacy received for lated 09/08/20. As last filled and dispensed on antity of 30 tablets. ew with the arge (SIC) on 04/30/21 at acted Resident #3's medications are pharmacy received for lated 09/08/20. As last filled and dispensed on antity of 30 tablets. ew with the arge (SIC) on 04/30/21 at acted Resident #3's medications as not available then it was not reacy. As document administration of the MAR when she administered are orecall the last time Resident acted omeprazole.	C 330				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BUILDING: _			
		FCL032088	B. WING		R 04/30/2021	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
ELSIE-DO	RIS FAMILY CARE HOM	E	RYGROVE STR NC 27703	REET		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE	
C 330	Continued From page	e 35	C 330			
	administration record -There was an entry of daily scheduled for an 8:00pmThere was documen was administered at a through 03/29/21There was no docum was administered at a through 03/31/21. Review of Resident # administration record -There was an entry of daily scheduled for an 8:00pmThere was documen was administered at a through 04/29/21There was no documen	for gabapentin 300mg twice dministration at 8:00am and station gabapentin 300mg 8:00am from 03/01/21 mentation gabapentin 300mg 8:00pm from 03/01/21				
	hand on 04/29/21 at -Gabapentin 300mg v administration.	was available for was dispensed on 04/02/21				
	the facility's contracted 11:16am revealed: -The order for gabape 04/02/21.	with a representative from ed pharmacy on 04/30/21 at entin twice daily was dated pensed on 04/02/21 for a				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					R
		FCL032088	B. WING		04/30/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	JE ZIP CODE	
	10115211 011 001 1 21211		RYGROVE STE		
ELSIE-DO	RIS FAMILY CARE HOM	E	, NC 27703	\	
()(1) ID	STIMMARY ST	TATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTIO	N OVE
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
C 330	Continued From page 36		C 330		
	4:03pm revealed: -She administered RedailyShe administered garanter of the telephon Administrator on 04/3 c. Review of Resident Manual Review of Resident Manual Refer to the telephon Administrator on 04/3 c. Review of Resident Manual Review of Resid	esident #3's medications abapentin twice daily. Ident administration of ations on the March and April with Resident #3 on 04/29/21 Incressful. Inc			
	-Benztropine 1mg wa administration.				

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1mg was dispensed on 04/26/21 for a quantity of

STATE FORM 6899 EKQJ11 If continuation sheet 37 of 51

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		FCL032088	B. WING		04/3	0/2021
	ROVIDER OR SUPPLIER	306 CHER	DRESS, CITY, STA RYGROVE STF NC 27703			-
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
C 330	1mg was unopened we tablets remaining. Telephone interview we the facility's contracted 11:16am revealed: -The pharmacy filled every monthThe last order received dated 09/17/20The medication was 04/26/21 for a quantity. Telephone interview we Care Provider (PCP) revealed: -Resident #3's current benztropine 1mg oncounty-the expected Reside administered as orde. Telephone interview we Supervisor-In-Charged 4:03pm revealed: -She was sure that she #3's benztropineShe did not realize be documented on the Month of 12021She could not say we container of benztrop medication administer.	container of benztropine with 30 benztropine 1mg with a representative from ad pharmacy on 04/30/21 at Resident #3's benztropine ed for benztropine was last filled and dispensed on y of 30 tablets. with Resident #3's Primary on 04/30/21 at 9:18am It medications included e daily. Int #3's medications to be red. with the e (SIC) on 04/30/21 at the administered Resident lenztropine was not larch 2021 MAR. In why she did not document benztropine 1mg on April thy the bubble-packed ine was unopened with no red. with Resident #3 on 04/29/21	C 330			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		FCL032088	B. WING		04/30	0/2021
	ROVIDER OR SUPPLIER	306 CHERF	RESS, CITY, STARYGROVE STR			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
C 330	O4/30/21 at 11:29am -She expected the Sloas orderedIf a medication was r contact the pharmacy -She had not been chemedications were adreshe expected the Sloshe administered a mache had no idea what the facility had no sy SIC to ensure she do administered. The facility failed to enter the Sloshe had no idea what the facility had no sy SIC to ensure she do administered.	e interview with the 0/21 at 11:29am. with the Administrator on revealed: C to administer medications not available the SIC should and the resident's PCP. ecking to ensure ministered as ordered. C to initial immediately after redication. at was going on with the SIC. ystem to check behind the cumented medications as	C 330			
	The facility failed to ensure medications were administered as ordered related to not administering medication to prevent the formation of blood clots which placed the resident at risk for a blood clot, not administering bacterial ointment which could increase the risk of infection of the surgical site, not administering a pain medication which could cause increased pain due to surgery from a broken hip, and not administering a laxative which could cause constipation and stomach discomfort (#1), not administering medication to reduce acid reflux which could cause stomach burning and irritation, not administering medication for nerve pain which could cause increased pain, numbness, and tingling, and not administering medication for muscle spasms which could cause muscle tension, tightness and severe pain (#3). This failure placed the residents at substantial risk of physical harm and neglect which constitutes a					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING:			SURVEY PLETED	
		FCL032088	B. WING		04	R / 30/2021
	ROVIDER OR SUPPLIER	306 CHE	ADDRESS, CITY, STATE ERRYGROVE STRE M, NC 27703		·	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
C 330	this violation. CORRECTION DATE	a plan of protection in 131D-34 on 04/29/21 for	C 330			
C 341	10A NCAC 13G .1004 Administration 10A NCAC 13G .1004 (i) The recording of the medication administration admin	4 Medication Administration the administration on the ation record shall be by the sinisters the medication administration of the ident and observation of the ag the medication and prior of another resident's	C 341			
	facility failed to ensuradministration of med following the administration the resident taking the sampled residents (Rother findings are: 1. Review of Resident	ews and interviews, the e staff documented the lications immediately tration and observation of e medication for 2 of 3				
	12/26/20 revealed: -Diagnoses included	hypertension, mild				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BUILDING: _			_
		FCL032088	B. WING		I	R 30/2021
NAME OF PR	OVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
ELSIE-DOR	RIS FAMILY CARE HOM		RYGROVE STF , NC 27703	REET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPIDEFICIENCY)	OULD BE	(X5) COMPLETE DATE
	-There was a handwr under "Medications" of the control of the cont	cations listed on the FL2. itten note "see attached list" on the FL2. ation list attached to the 2's April 2021 medication (MAR) revealed: or metoprolol 25mg twice dministration at 8:00am and tation metoprolol 25mg was aily at 8:00am 04/01/21 aual documentation) mentation metoprolol 25mg 3:00pm from 04/01/21 ent #2's medications on 04/29/21 at 11:58am as available for as filled on 04/05/21 and a awas dispensed. brolol 25mg tablets with a representative from ad pharmacy on 04/30/21 at rolol 25mg was dispensed 020. d the MARs for the facility tion on the MAR was	C 341			

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPL	ETED
					F	₹
		FCL032088	B. WING		04/3	30/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
FI SIF-DO	RIS FAMILY CARE HOM	306 CHER	RRYGROVE STE	REET		
	NO FAMILI GARLIONI	DURHAM	, NC 27703			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
C 341	Continued From page	÷ 41	C 341			
	4:37pm was unsucce	ssful.				
	Attempted interview v at 9:38am was unsuc	vith Resident #2 on 04/29/21 cessful.				
	Refer to interview with on 04/29/21 at 12:30p	h the Supervisor-In-Charge om.				
	Refer to the telephon- Administrator on 04/2					
	Review of Resident #3's current FL2 dated 10/22/20 revealed: -Diagnoses included schizoaffective disorder, depression, and dysphoria. -There were no medications listed on the FL2. -There was handwritten documentation "see					
	attachment" under the	e "medications" of the FL2. ments attached to the FL2. ed medication list in				
	administration record -There was an entry f	3's March 2021 medication (MAR) revealed: for gabapentin 300mg twice for administration at 8:00am				
	-There was documen was administered one -There was no docum	tation gabapentin 300mg ce daily at 8:00am. nentation gabapentin 300mg 3:00pm from 03/01/21				
	daily schedule for adr 8:00pm.	3's April 2021 MAR for gabapentin 300mg twice ministration at 8:00am and tation gabapentin 300mg				

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was administered once daily at 8:00am.

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DIVISION	or riealin Service Regu	lation			
	Γ OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
			_		_
			D. WING		R
		FCL032088	B. WING		04/30/2021
NAME OF D		STDEET AD	DRESS, CITY, STA	TE 710 CODE	
NAIVIE OF P	ROVIDER OR SUPPLIER				
ELSIE-DO	RIS FAMILY CARE HOMI	E	RYGROVE STR	REET	
		DURHAM	NC 27703		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)
PRÉFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	
TAG	REGULATORY OR L	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	RIATE DATE
				DEFICIENCY)	
C 341	Continued From page	12	C 341		
0011	Continued From page	, 12			
	-There was no docum	nentation gabapentin 300mg			
	was administered at 8	3:00pm from 04/01/21			
	through 04/29/21.				
	Observation of Reside	ent #3's medications on			
	hand at the facility on				
	revealed:	04/29/21 at 11.59am			
	-Gabapentin 300mg v	vas avaliable for			
	administration.				
		vas filled on 04/02/21 and a			
	quantity of 60 tablets	was dispensed.			
	-There were 15 gabar	pentin 300mg tablets			
	remaining.				
	Telephone interview w	vith Resident #3's Primary			
		on 04/30/21 at 9:18am			
		's current medications			
	included gabapentin 3	booring twice daily.			
	T-1				
		vith a representative from			
	•	ed pharmacy on 04/30/21 at			
	11:16am revealed:				
	-Resident #3's gabap	entin 300mg was cycle filled			
	monthly.				
	-The last order receiv	ed for gabapentin 300mg			
	twice daily was last fil	lled and dispensed on			
	04/02/21 for a quantit				
		,			
	Attempted interview w	vith Resident #3 on 04/29/21			
	at 9:40am was unsuc				
	at 0. Iodili was alisao				
	Pofor to intensious with	h the Supervisor In Charge			
		h the Supervisor-In-Charge			
	on 04/29/21 at 12:30p	om.			
	Refer to the telephone				
	Administrator on 04/2	9/21 at 11:29am.			
	Interview with the Sup	pervisor-In-Charge (SIC) on			
	04/29/21 at 12:30pm.				

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-"Honestly," she did not sign the MAR each time

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		FCL032088	B. WING		R 04/30/2021
NAME OF PI	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE	1 04/30/2021
ELSIE-DO	RIS FAMILY CARE HOM	306 CHERF E DURHAM, I	RYGROVE STR	REET	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
C 341	(04/29/21) so she wor-She was aware that MAR each time a mer-Sometimes she forgot Telephone interview words at 11:29am. She expected the Stradministration of a retime she administered. She did not know the as required.	dents' medications. locument on the MAR today uld not get in trouble. she had to document on the dication was administered. of to document on the MAR. with the Administrator on revealed: C to document the sident's medication each d a medication. e SIC was not documenting	C 341		
C 367	as requiredShe had not been at the facility lately. C 367 10A NCAC 13G .1008(a) Controlled Substances 10A NCAC 13G .1008 Controlled Substances (a) A family care home shall assure a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure a retrievable record of controlled substances was maintained and reconciled accurately for 1 of 3 sampled residents (Resident #2) related to the administration of an anti-anxiety medication. The findings are:		C 367		

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE S	
ANDILAN	OF CONTLOTION	IDENTIFICATION NOMBER.	A. BUILDING: _		COMIL	LILD
		FCL032088	B. WING		I	R 30/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
ELSIE-DO	RIS FAMILY CARE HOM	E	RYGROVE STR	REET		
		DURHAM,	NC 27703			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
C 367	Continued From page	e 44	C 367			
	12/26/20 revealed: -Diagnoses included mild intellectual disabterThere were no mediffleThere was no order (a schedule IV narcon Review of Resident # medication administrationThere was an entry daily scheduled for an antere was document.	schizoaffective disorder, bility, and hypertension. cation orders on the current for clonazepam on the FL2 tic used to treat anxiety).				
	substance count shee-There was a printed clonazepam 1mg atta the CSCSClonazepam 1mg was but was documented through 01/31/21There was documented dispensed on 03/26/2-The beginning date 01/01/21 with the cou-The end date was on ending of 0 tablets, we clonazepam 1mg was dispensing date on 0-There was no consist.	pharmacy label for ached to the top left side of as dispensed on 03/26/21, as signed out from 01/01/21 tation for a total of 30 tablets 21 on the CSCS. on the CSCS was on ant starting at 30 tablets. In 01/31/21 with the count which was incorrect if a administered based on the				
	revealed: -There was an entry	2's February 2021 MAR for clonazepam 1mg once dministration at 8:00am.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING:			E SURVEY PLETED	
			A. BOILBING.			В
		FCL032088	B. WING		04	R //30/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE	, ZIP CODE		
EL OIE DO	DIO FAMILY CADE LION	306 CHEI	RRYGROVE STRE	ET		
ELSIE-DO	PRIS FAMILY CARE HOM	DURHAM	I, NC 27703			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCED	ΓΙΟΝ SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
C 367	67 Continued From page 45		C 367			
		ntation clonazepam 1mg was aily from 02/01/21 through				
	revealed: -There was a printed clonazepam 1mg attathe CSCSClonazepam 1mg w but documented as sthrough 02/28/21There was documendispensed on 02/23/2The beginning date 02/01/21 with the country of 2 tablets resulting of 2 tablets resulting of 30 tablets resulting the quantity of 30 tablets.	as dispensed on 02/23/21 digned out from 02/01/21 distation for a total of 30 tablets 21, on the CSCS. Son the CSCS was on curt starting at 30 tablets. In 02/28/21 with a count emaining. Insing date on 02/23/21 and oblets dispensed, there should blets remaining in				
	revealed: -There was an entry daily scheduled for a -There was documer administered once da 03/30/21.	for clonazepam 1mg once dministration at 8:00am. Intation clonazepam 1mg was aily from 03/01/21 through				
	revealed: -There was a printed clonazepam 1mg attathe CSCSClonazepam 1mg was total of 30 tabletsClonazepam 1mg w	pharmacy label for ached to the top left side of as dispensed on 12/18/20 for as documented as signed rough 03/30/21 on the CSCS.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDING		_
		FCL032088	B. WING		R 04/30/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
		_ 306 CHE	RRYGROVE STR	REET	
ELSIE-DO	RIS FAMILY CARE HOM	E DURHAN	M, NC 27703		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
C 367	Continued From page	e 46	C 367		
	-There was document beginning date was of starting at 30 tabletsThe end date was or ending of 1 tablet remembers about the dispension of the accuracy of the Codetermined. Review of Resident # revealed: -There was an entry for daily scheduled for accurate was document to the accuracy of the Codetermined.	tation on the CSCS the n 03/01/21 with the count n 03/30/21 with a count naining. sing date on 12/18/20 and 03/01/21 through 03/30/21, SCS could not be			
	Review of Resident #2's April 2021 CSCS revealed: -There was a printed pharmacy label for clonazepam 1mg attached to the top left side of the CSCS. -Clonazepam 1mg was dispensed on 01/15/21 for a total of 30 tablets. -Clonazepam 1mg was documented as signed out from 04/01/21 through 04/290/21 on the CSCS. -There was documentation on the CSCS the beginning date was on 04/01/21 with the count starting at 30 tablets. -The end date on 04/30/21 was completed in advance with a count ending of 1 clonazepam tablet remaining. -Based on the dispensing date on 01/15/21 and documentation on the CSCS that clonazepam 1mg was signed out from 04/01/21 through 04/29/21, it could not be determined the month				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X: A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			7. BOILDING:			R
		FCL032088	B. WING		04	1/30/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE		
		306 CHE	RRYGROVE STRE			
ELSIE-DO	RIS FAMILY CARE HOM	E	II, NC 27703			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CO		(X5) COMPLETE DATE	
C 367	C 367 Continued From page 47		C 367			
	on hand at the facility	ent #2's clonazepam 1mg v 04/29/21 at 11:58am n was dispensed on 04/05/21 clonazepam tablets				
	pharmacy on 04/30/2 -Resident #2's clonaz monthly.	with the facility's contracted 1 at 11:45am revealed: tepam 1mg was dispensed				
	-The pharmacy sent CSCS with each supply of clonazepam for documentation and accuracy purposesIf the facility did not know how to complete the CSCS they should have called and asked for					
	instructions.					
	04/29/21 at 12:55pm	oleted these sheets today so				
	-She knew she was s	supposed to document on administered Resident #2's				
	-The Administrator had complete the CSCS,	but she got confused.				
		or assistance from anyone for completing the CSCS				
	04/30/21 at 11:41am -The SIC knew she w	with the Administrator on revealed: vas supposed to complete administered Resident #2's				
	-If the SIC did not und the CSCS she should of not documenting it	derstand how to complete I have asked for help instead . ave a system of monitoring				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		FCL032088	B. WING		R 04/30/2021		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE BLSIE-DORIS FAMILY CARE HOME 306 CHERRYGROVE STREET DURHAM, NC 27703							
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE		
C 367	necessary documenta medications.	o her job and complete the ation when administering	C 367				
C 914	G.S 131D-21(4) Declaration Of Resident's Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure residents were free of neglect related to medication administration. The findings are: Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered by a licensed prescribing practitioner for 2 of 3 sampled residents (Residents #1 and #3) related to an anticoagulant injection, an antibiotic ointment, a pain medication and a powdered laxative (#1), a proton pump inhibitor, nerve pain and muscle spasms medications (#3).[Refer to Tag 330 10A NCAC 13G .1004(a) Medication Administration (Type A2 Violation)].		C 914				
C992	G.S. § 131D-45 G.S. and screening for G.S. § 131D-45. Exar	§ 131D-45. Examination mination and screening for olled substances required sloyment in adult care	C992				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		IDENTIFICATION NUMBER:					
			_		_		
			5 14/11/0		R		
		FCL032088	B. WING		04/30/2021		
NAME OF D	OVIDED OD CUDDUED	CTDEET ADE	DECC CITY CTA	TE 710 CODE			
NAIVIE OF PI	ROVIDER OR SUPPLIER		RESS, CITY, STA				
FI SIF-DO	RIS FAMILY CARE HOM	S 306 CHERI	RYGROVE STR	REET			
LLUIL-DO	INO I AMILI OAKL HOM	DURHAM,	NC 27703				
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5	.)	
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	, ,		
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPR	IATE DAT	E	
				DEFICIENCY)			
C992	Oti	- 40	C992				
C992	Continued From page	e 49	C992				
	(a) An offer of employ	ment by an adult care home					
		rticle to an applicant is					
		oplicant's consent to an					
	examination and scre						
		mination and screening shall					
		_					
		rdance with Article 20 of					
	•	neral Statutes. A screening					
		s a single-use test device					
	-	examination and screening					
		y be administered on-site. If					
		licant's examination and					
	screening indicate the	e presence of a controlled					
	substance, the adult care home shall not employ the applicant unless the applicant first provides to						
	the adult care home written verification from the						
	applicant's prescribing physician that every						
	controlled substance identified by the						
	examination and screening is prescribed by that						
	physician to treat the applicant's medical or						
	psychological condition. The verification from the						
	physician shall include the name of the controlled						
	substance, the prescribed dosage and frequency,						
	and the condition for which the substance is						
	prescribed. If the result of an applicant's or						
	•	• •					
	employee's examination and screening indicates the presence of a controlled substance, the adult care home may require a second examination						
	· ·						
		fy the results of the prior					
	examination and scre	ening.					
	This Date 1 1 1						
	This Rule is not met						
		and record reviews, the					
	facility failed to ensure						
	screening for the presence of controlled substances was completed for 1 of 2 sampled						
	staff (Staff A) prior to	hire.					
	The findings are:						
	-		1		1		

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Review of Staff A's, Supervisor-In-Charge (SIC),

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, JP CODE 306 CHERRYGROVE STREET DURHAM, NC 27703 CALID PREPIX SUMMARY STATEMENT OF DEFICIENCES DURHAM, NC 27703	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
ELSIE-DORIS FAMILY CARE HOME Continued From page 50 Continued From Page 50 Personnel records revealed:			FCL032088	B. WING		1	
CALL DEPTICE CARE HOME DURHAM, NC 27703	NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE DATE COMMITTEE COMMITTEE DATE COMMITTEE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMMITTEE COMMITTEE DATE COMMITTEE DATE COMMITTEE DATE COMMITTEE DATE COMMITTEE DATE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMMITTEE DATE COMMITTEE COMMITTEE DATE COMMITTEE COMMITTEE DATE COMMITTEE COM	ELSIE-DO	RIS FAMILY CARE HOMI			REET		
personnel records revealed: -Staff A was hired on 07/10/15There was no documentation Staff A completed an examination and screening for the presence of controlled substances prior to hire. Interview with Staff A on 04/29/21 at 1:00pm revealed: -She thought that she completed a drug screen when she was hiredShe did not know where the paperwork was located. Interview with the Administrator on 04/30/21 at 11:45am revealed: -Staff A was the only staff who worked at the facilityStaff A had been employed at the facility since 2015 and had completed a drug screeningShe did not know what Staff A had done with her	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETE
	C992	personnel records revestaff A was hired on There was no document examination and substances. Interview with Staff A revealed: -She thought that she when she was hiredShe did not know who located. Interview with the Adra 11:45am revealed: -Staff A was the only stacilityStaff A had been empleated and had completed.	realed: 07/10/15. nentation Staff A completed creening for the presence of s prior to hire. on 04/29/21 at 1:00pm completed a drug screen ere the paperwork was ministrator on 04/30/21 at staff who worked at the ployed at the facility since sted a drug screening.	C992			

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